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TASK FORCE II
REPORT ON THE
OPERATION AND
EFFECTIVENESS OF

THE ONTARIO DETOXICATION SYSTEM

ADDICTION
RESEARCH
FOUNDATION
OF ONTARIO

Helen Annis
Norman Giesbrecht
Alan Ogborne
Reginald G. Smart

NOV 1 7 1979

THE ONTARIO DETOXICATION SYSTEM

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Toronto, Ontario

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Preface

The members of Task Force II on Detoxication are to be commended for providing the evaluation data contained in this report.

As we work toward an enlightened approach to the plight of the chronic drunkenness offender, our objective must remain constant: To further decriminalize public drunkenness while increasing and improving our care and rehabilitation efforts.

The research and evaluation component, which is the basis of this report, was determined at the outset of the Ontario detoxication system. The evaluation was concerned with the ways in which the system decriminalized drunkenness and provided rehabilitation and care for chronic police arrestees.

The number of detoxication centres, the location in the community in relationship to the hospital and the number of back-up rehabilitation centres were all determined as a beginning model of a new health care program. The research and evaluation component was designed to provide feedback on this initial establishment so that future planning can progress in this area.

This evaluation should be seen as positive feedback for future change. Its general aim is to contribute to the development of more effective care and rehabilitation of chronic police arrestees.

W.E. Boothroyd, M.D.
Acting Executive Director (ARF)

Note on the Task Force Members and Mandate of the Group

The Task Force II on Detoxication was established on June 25, 1975 to bring together research relevant to the Ontario Detoxication and Halfway House systems. It arose out of a meeting involving: Mr. H.D. Archibald, Dr. W.E. Boothroyd, Mr. R.E. Popham, Mr. G. Toombs, Prof. J. Giffen, Ms. J. Fowlie, Dr. H. Annis, Dr. A. Ogborne, Dr. R. Smart, and Mr. D. Smith. This meeting was concerned with early results of researches on the operation and effectiveness of the Ontario Detoxication System. The mandate of the Task Force was to:

(i) bring together data relevant to the impact of detoxication centres;

(ii) consider and make recommendations concerning novel approaches and alternative models;

(iii) prepare a report on the above issues for discussion with the larger group named above and with the Interministerial Co-ordinating Committee on Detoxication and Halfway Houses.

The members of the Task Force were:

Dr. R. Smart (Chairman)
Dr. H. Annis
Mr. N. Giesbrecht
Dr. A. Ogborne

A large number of meetings were held and in May, 1976, the Task Force reported back to the larger group. After thorough discussion and some revision the report presented herewith was approved for publication.

I. *TRADITIONAL METHODS OF HANDLING DRUNKENNESS OFFENDERS IN ONTARIO*

Prior to the 1970s the method of handling drunkenness offenders in Ontario was through arrest, trial, and, in many cases, jail sentences. This approach created a cycle of intoxication, legal intervention, and subsequent intoxication. This cycle was a definitive feature of the life of the skid row inebriate. Police typically arrested only homeless alcoholics and drunks creating a disturbance. Offenders usually spent a night in jail and appeared in court the next day to almost invariably receive a fine with a jail term in default of payment. In over 90% of the cases the persons were unable to pay the fine and therefore served jail terms of varying lengths, with 30-day jail sentences not being an uncommon disposition.

This approach generated a large number of drunk convictions in Ontario (56,290 in 1966) with about 43% of them in Toronto (24,075 in 1966). About 40% of those arrested in Toronto were repeaters. It was established that in the City of Toronto in 1961 there were 3,353 persons with two or more convictions for public drunkenness in 12 months, of which 2,990 were males and 363 were females.

Informed opinion of the legal processing of chronic police arrestees(1) (for drunkenness) was that this approach brought

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(1) Throughout the authors have attempted to use the term chronic police arrestee instead of the terms chronic drunkenness offender, skid row offender, or public inebriate, except where others work is quoted. In this report we are concerned only with arrests for drunkenness and related offences. It is known that police are more likely to arrest skid row persons and habitual offenders than they are persons not known to them. Chronic police arrestees are likely to have skid row characteristics.

few benefits to the arrestees or to society. Critics of the system pointed to the endless court parade involving the same persons as evidence that the system was not deterring public intoxication in this population. The petty nature of many of the offences committed by the arrestees made it difficult to sustain the illusion that society was protecting itself from dangerous felons by committing such arrestees to jail.

Most persons charged with public drunkenness, and particularly the recidivists, plead guilty believing that their cases were unfairly conducted and that police and magistrates colluded against them. Those interested in the health, social functioning, and rehabilitation of the drunkenness offender saw few advantages of the system of legal processing. Jail seemed to be part of the skid row acculturation process and of little rehabilitative value. The only benefit from the revolving door system seemed to be that incarceration created some stability in the lives of the arrestees. It enforced periods of abstinence and created opportunities for basic medical care and nutrition for at least a part of the year (Giffen et al., 1971).

A few social and treatment agencies existed during the 1960s and for many years charitable organizations provided food, clothing, and shelter to the public inebriate. Some of these places may have perpetuated the skid row way of life by reinforcing dependency—for example, by offering meals at times when employed men could not get them.

Halfway houses, clinic and hosptial programs intended especially for skid row inebriates were rare. Some hostels and missions did exist but they tended to be selective in the cases that they admitted (frequently called "mission stiffs" on skid row) and evidence that they were particularly effective was not available. Despite centuries of effort to control the police arrestee by judicial, religious, and social means the prospect of achieving it looked as dim as ever in the mid 1960s. Drunkenness arrests in Ontario had increased from 43,181 in 1957 to 56,290 in 1966 and showed no signs of diminishing from either natural causes or planned interventions.

Frustration with these circumstances and a desire to improve upon them led to the formation of several groups

which recommended new approaches to the chronic police arrestee. One group within the Addiction Research Foundation established a medical detoxication centre (Robinson, 1970) in 1968. Thereafter an ARF Task Force on Detoxication Planning was set up which in turn led to an Interdepartmental Committee on Chronic Drunkenness Offenders. This committee was composed of members from various government departments (ARF, Justice, Correctional Services, Health, Social and Family Services). The recommendations of these groups led to the development of the current system of detoxication and halfway house facilities and played a role in the changes in legislation and police and court practices.

II. THE REPORT OF THE TASK FORCE ON DETOXICATION

The Task Force began its work in 1968 and submitted its report in May 1969. The main recommendations are provided in Appendix A. The aims of the report were not set out in detail but a memo from H.D. Archibald, establishing the group indicated that the Task Force was to consider:

(1) The kind and number of detoxication facilities required in Metropolitan Toronto to "make a reasonable" impact on handling the problem of the chronic drunkenness offender (CDO) within the context of health.

(2) The kind and number of facilities beyond detoxication, e.g. halfway houses and long care units, required to complement the detoxication and diagnostic function.

The main recommendations were that detoxication centres should be established in large centres and that police should be empowered to take inebriates to them after arrest and in lieu of laying charges. Toronto was to have a large downtown detoxication centre of 125 beds, with arrangements with suburban hospitals. A multi-service centre was to take care of diagnosis and referral to residential treatment facilities and in particular to inexpensive "self-help" units which would be newly established.

III. THE INTERDEPARTMENTAL COMMITTEE ON CHRONIC DRUNKENNESS OFFENDERS

The report of this Committee was submitted in January, 1972. Its recommendations are provided in Appendix B. In summary, this Committee recommended that police be allowed to take inebriates to detoxication centres established in connection with hospitals. It was proposed that 125 beds should be available for Toronto with no more than 20 beds per unit. Detoxication facilities were also recommended for areas having at least 1,000 public drunkenness arrests per year. The establishment of halfway houses and long stay facilities such as Bon Accord farm was also proposed. The Committee further recommended that statutory authority be provided to forcibly detain patients in detoxication centres for up to 24 hours. All recommendations except that for compulsory detention in detox centres were accepted by the government.

The Liquor Control Act (Bill 101) was amended by the Ontario Government in the summer of 1971 and the police were thereby empowered to take drunk arrestees to designated detoxication centres "in lieu of laying an information in respect of the contravention" of being intoxicated in a public place. Public intoxication was, however, still to be considered an offence.

The Ministry of Health was empowered to set up detoxication centres while the Ministry of Community and Social Services was charged with the development of suitable post detoxication facilities such as halfway houses. The Addiction Research Foundation was requested to assume responsibility for staff training and evaluation of the programs.

IV. THE OBJECTIVES OF THE DETOXICATION - HALFWAY HOUSE PROGRAM

The objectives of the detoxication halfway house programs were outlined in the legislature debates in Bill 101 and in ministerial submissions on the program approved by the Social Development Policy Field Committee of Cabinet. The program was clearly to provide "care and rehabilitation for the chronic liquor offender,"(2) and for this reason detoxication facilities were first to be established in judicial districts of the province having more than 1,000 arrests per annum for public intoxication. It was clearly recognized that given the limited number of facilities to be established, there could be "no hangover havens in these figures,"(3) and that the program, at least initially, would be unable to deal with "non-chronic drunkenness offenders" who might wish to commit themselves voluntarily to such centres.(4) The program, then, was established specifically as an alternative to jail for drunk police arrestees who had previously been involved in the criminal revolving-door system.

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(2) Hon. A.F. Lawrence, Legislature of Ontario Debates, Fourth Session of the Twenty-Eighth Legislature, July 6, 1971.

(3) Hon. A.B.R. Lawrence, Legislative Assembly of Ontario, Ontario Supply Committee, May 17, 1971.

(4) Hon. A.F. Lawrence, Legislature of Ontario Debates, Fourth Session of the Twenty-Eighth Legislature, July 13,1971.

In the two-part program of detoxication centres and halfway houses approved by government, the detoxication centres were designed to achieve the short-term rehabilitative objective of removing the chronic police arrestee from the jail system into the health care system. Through a process of referral, the detoxication centres were designed to promote (i) the integration of the chronic offender into health care facilities in the province, and (ii) referral to the halfway houses set up specifically to achieve long-term rehabilitative objectives with this population. These halfway houses were "not to serve as chronic care homes for alcoholics--(but) as centres from which the individual could re-establish himself in the community."(5) The halfway houses focused on accommodation opportunities, recreational activities, sources of financial support, counseling services and health care agencies in the community, as well as programs available in job training and placement. All of these efforts were designed "to link the individual with other systems outside the house"(5) in order to achieve long-term rehabilitative objectives.

The present Committee's reading of the recommendations and reports of the Task Force and Interdepartmental Committee, and in particular our reading of the statements of the objectives of the detoxication-halfway house programs leads us to the following conclusion:

1. The system was planned and built to serve the needs of the chronic drunkenness offender or police arrestee. It was not meant to provide facilities for the detoxication and rehabilitation of all types of alcoholics or intoxicated persons.

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(5) Ministry of Community and Social Services, Submission to Social Development Policy Field Committee of Cabinet, Addendum to Original Submission on Hafiway Houses for Alcoholics, January 30, 1973.

V. *FACILITIES ESTABLISHED UNDER THE GOVERNMENT PROGRAMS*

Funding for the detoxication centres is on a 100% basis while that for halfway houses is 80% of their operating costs based on occupancy. Legal responsibility for the operation of each detoxication centre rests with a sponsoring local hospital. The centres are mainly staffed by para-professionals who become employees of the hospital. The detoxication centres are non-medical in the sense that no physicians are on the staff of the centres. The non-medical staff are selected and trained to identify cases which require immediate medical attention and are responsible for transporting such cases (about 3% of total admissions) to the emergency department of the sponsoring hospital.

In the case of the halfway houses, voluntary community boards are responsible for policy and program within the house. Houses differ in ideology and operation. Although most emphasize informality and the development of a "homelike atmosphere," a few houses are more treatment oriented and have developed structured programs of rehabilitation. The two programs supported by ARF (Bon Accord and 142 Spadina Avenue) are being run along experimental lines in order to determine the value of the various elements of programs and in-house structure.

Selection and supervision of detox staff are the responsibility of the parent hospital while the local Community Boards have these responsibilities for halfway houses. The Addiction Research Foundation runs regular one-week training courses for staff of both types of facilities. These

courses have not generally been attended by halfway house staff with the exception of one newly opened halfway house, whose entire staff came to the Foundation for training. All detox directors have been trained by the Foundation and as new units open all staff attend the Foundation course. Regular site visits are made by ARF training co-ordinators and such visits are aimed to contribute to the ongoing training of detox staff.

Both detoxes and halfway houses employ former alcoholics as staff members. The percentage of staff in detoxes who have had alcohol problems is estimated to be in excess of 70%; while in a recent survey 39% of staff of 17 halfway houses said that they had had drinking problems. In addition to the staff who are employed by individual halfway houses, each house may use the services of one full-time professional rehabilitation counselor from the Ministry of Community and Social Services. The use of counseling services and the involvement of counselors in the houses varies considerably from house to house. In addition to paid staff most detox and halfway house facilities make some use of volunteers, in particular, members of Alcoholics Anonymous.

An annual conference is held by the Ontario Recovery Homes Association and this conference is attended by many staff from both types of facilities.

At present the Ministry of Health funds 13 detoxication centres (265 beds) and the Ministry of Community and Social Services supports 17 halfway houses (290 beds).(6) Appendix C shows the dates of opening and some other characteristics of all detoxication centres in Ontario, including four early detox programs which were not funded by the Ministry of Health and which have subsequently closed. Of the 13 government programs, 10 were operational as of February 1974, and by the same time 11 of the 17 halfway houses were in operation. Although no complete information is available, it is clear that, in addition to the 10 ministry funded halfway houses, which were functioning in February 1974, there were at least 13 other halfway house programs operating at that time. Most elements in the system have had two years or more of operation and extensive changes in

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(6) A number of facilities dealing with alcoholics commonly have one or two beds set aside for detoxication and there are at least 13 other halfway houses not funded through the program. No accurate estimates are available of the number of such beds in the province.

the number or type of facilities are not planned for the near future. The ways in which the detoxication centres are operating appear to have stabilized.

Among the many conclusions which follow from the material presented in this section, the following seems the most pertinent to our task.

2. The key features of the detox-based system have been in operation long enough to establish their contribution to the rehabilitation of the chronic police arrestee.

VI. CHARACTERISTICS OF DETOX AND HALFWAY HOUSE ADMISSIONS

Appendix D presents a summary of the characteristics of 8,112 male and 613 female first admissions to 13 provincial detoxication centres and 747 consecutive male admissions to 17 halfway houses throughout the province. Appendix E provides a breakdown of length of stay for each detoxication unit.

The men and women admitted to the detoxication centres showed a wide range of demographic characteristics, recent accommodation, employment history, and involvement with the law. A large proportion of admissions did not exhibit the degree of social instability characteristic of chronic police arrestees. Many had stable accommodation and family ties and good employment records. About half had not been arrested for drunkenness in the previous year.

The mean length of stay of detoxication admissions varied greatly between centres ranging from 1.8 days to 4.8. In some centres, only a small minority of admissions stayed less than 24 hours, whereas in other centres over half of all admissions were discharged within 24 hours.

Comparison of male and female detoxication admissions reveals that female admissions tended to be more socially integrated than males. They were more likely to have an ongoing relationship with the opposite sex and to have a stable accommodation arrangement. They were also more likely to have children--a factor which undoubtedly contributed to their lower involvement than male admissions in the labor force. Although females were as likely as males to

have been arrested, they were much less likely to have been sentenced to jail. Female admissions reported a lower frequency of drinking than males, and reported less contact with outpatient and residential treatment facilities.

Men admitted to halfway houses exhibited more homogeneity on most characteristics than the general detoxication population and tended, on the whole, to exhibit less social integration. For example, compared to the general detoxication population, halfway house residents were less likely to be married or living common-law, less likely to have had stable living arrangements or accommodation, and more likely to have been recently arrested and served time in jail. They were also more likely to have had prior contact with outpatient or residential treatment facilities, indicating greater institutional dependency among the halfway house population.

The following conclusions are most pertinent to our task:

3. Upward of 50% of detox admissions have not been arrested for drunkenness in the past year, and many admissions have stable accommodation and family ties. (NOTE: Stable accommodation and family ties are typically not found among chronic police arrestees.)

4. There is a great variability among detoxication centres in mean length of stay of residents (range 1.8 days to 4.8 days). In some centres, only a small minority of admissions stay less than 24 hours, whereas in other centres, over half of all admissions are discharged within 24 hours.

VII. INVOLVEMENT OF DETOX USERS IN LONG-TERM HEALTH CARE FACILITIES

The rate of successful referral from detoxication centres to other health care facilities has been found to be approximately 10% for first admissions but to drop off slightly for second and subsequent admissions (Annis and Smart, 1976). In one community, the opening of the detoxication centre was shown to stimulate an increase in admissions to post-detoxication health care facilities (Annis and Liban, 1975). Nevertheless, self-referrals and referrals by agencies other than detox account for the majority of admissions of this population into longer-term rehabilitation programs. Over a six-month period following admission to a detoxication centre, 45-50% of residents were found to establish some contact with a residential or outpatient health care facility (Annis and Smart, 1976; Annis and Liban, 1975). We, therefore, conclude that:

5. A large proportion of the population periodically establishes contact with other longer-term health facilities. Only about 10% of detox admissions are successfully referred to such facilities on discharge from detox. The referral rate on second and subsequent admissions decreases.

Unfortunately, there is considerable evidence that admission to post-detoxication facilities may be having rather limited rehabilitative impact on the client population. One large scale follow-up study found that, among those who had been admitted to residential or outpatient facilities, over 50% had also been arrested by the police and over 60% had

been re-admitted to a detoxication centre within a six month period. These percentages were actually higher than for those who had not entered outpatient or residential treatment (Annis and Smart, 1976). A second study, restricted to a follow-up of halfway house residents, found evidence of drunkenness episodes in 51% of the residents within three months of discharge from the halfway house. This percentage did not differ from that of matched control subjects who did not enter a halfway house (Annis and Liban, 1976(a)).

A major difficulty in rehabilitating this population is retaining them in treatment long enough. In the case of outpatient facilities, the majority of clients in this population are not retained in treatment beyond their second appointment (Annis and Smart, 1976; Annis and Liban, 1975; Smart, Finley, and Funston, 1975). In the case of residential facilities, only about 40% are still in treatment at the end of one month (Annis and Smart, 1976). Problems in retention and premature discharge have been documented within the Ontario halfway house programs specifically designed for this population (Ogborne, Ittig, and Weber, 1976), and such problems seem common to halfway houses elsewhere (Ogborne and Smart, 1974). Also unsettling is the finding of one study that the incidence of drunkenness following discharge is unrelated to the length of stay in a halfway house (Annis and Liban, 1976(a)). Study of the factors involved in successful rehabilitation would appear to be a high priority area for future research.

These studies lead us to two main conclusions:

6. Persons admitted to post-detoxication facilities do not have lower rates of detox readmission and drunkenness arrests than those who are not admitted.

7. Premature termination of treatment is the norm for halfway house populations and for detox referrals to both outpatient and residential facilities of all kinds.

A large scale follow-up of men admitted to detoxication centres found that 47% had been re-arrested at least once and 12% had been re-arrested six or more times within a six-month period (Annis and Smart, 1976). Arrest rates did not differ following admission of a man to a detoxication centre

from what they had been prior to his admission (Annis and Liban, 1975).

Readmission rates to detoxiction centres have also been found to be high. Over a two year period, 70% of all admissions were readmitted at least once (Annis and Liban, 1976(b)). Within a six month period, 52% had two or more admissions and 20% were admitted four or more times (Annis and Smart, 1976). These findings provide support for the claim that the detoxication program may be providing a faster revolving door than the former criminal system for the drunkenness offender. We are, therefore, led to conclude that:

8. There is little evidence of positive effects of detox on the clients' post-detox drinking behavior. On the average, arrests after detox admission do not decline. Readmission rates are as high as 70% over two years.

VIII. DRUNKENNESS ARRESTS, POLICE POLICY AND ATTITUDES

Comparison of drunkenness arrest figures before and after the opening of a detoxication centre in various Ontario jurisdictions has revealed a variety of trends. In some communities (e.g. Toronto and Thunder Bay), the number of drunkenness arrests has remained essentially the same in post-detoxication years; in other communities (e.g. Sudbury, Ottawa, and Windsor) the number of drunkenness arrests actually increased (Oki, et al., 1976; Annis and Smart, 1975; Annis and Liban, 1975). It should be kept in mind that a variety of factors including police attitudes, court policies, and the availability of rehabilitative and caretaker services can influence the number of drunkenness arrests. For these reasons, temporal changes in drunkenness arrest figures may not accurately reflect changes in the true number of public drunkenness events occurring in a community.

The number of police arrests for drunkenness may increase in response to the availability of diversionary facilities such as detoxication centres. This is the most likely outcome under conditions in which the diversionary detoxication facility can accommodate the majority of such arrests. When this is not the case, other factors such as police attitudes and court practices may become more important. Since the advent of the public health approach to drunkenness offenders in Ontario, there is evidence of increasing leniency on the part of the police and the courts in dealing with public drunkenness offenders (Oki, et al., 1976). For example, in Toronto in 1961, 90% of persons

arrested for public drunkenness received a fine or a jail term and in 1971 only 19% received these dispositions. Over the same period the proportion of suspended sentences increased from 6% to 73% and the estimated man-days served in jail dropped from 121,095 to 13,380.

More lenient and selective police policies can effect a decline in official arrest statistics, while at the same time greater leniency in court sentencing policies increases the "time at risk" of the offender population and thus the potential for a greater number of drunkenness events occurring in a community.(7)

One factor likely to influence police referral rates is the attitude of police officials towards a public health approach. One study conducted in downtown Toronto (Giesbrecht et al., 1976), found that although most of the policemen interviewed (mainly desk sergeants) were in favor of the public health approach, they expressed reservations about the operation of the detoxication system. A frequent criticism was that the detoxication centres did not keep the men out of circulation long enough and were not successful in referring men to longer-term treatment programs. The police expressed frustration about the "new approach," or rather, the combination of the "new" and "old" approaches. Some of the police expressed feelings of futility because many of the men they had arrested were back on the street within a few days or even hours after a detox admission or court appearance. The police also expressed frustration about the shortage of detoxication beds for police referrals.

The foregoing material leads us to the following conclusion:

9. Drunkenness arrests showed inconsistent changes after the introduction of the system. Such changes could be as much due to modifications in police and court policies and attitudes as to some specific effect of the detox halfway house system on the chronic police arrestee.

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(7) By more leniency is meant that police are less likely to arrest persons unless they are severely intoxicated and more likely to release such persons without requiring pre-trial incarceration. Leniency on the part of courts refers to the tendency to give more suspended sentences, fewer fines, and fewer jail terms.

An analysis of the disposition of drunkenness arrestees has revealed that in the first year detoxes were opened in seven of nine designated communities (including Toronto) only a minority of police-apprehended inebriates have been diverted into the detoxication system. In the second year that detoxes were opened in four of the eight communities only a minority had been diverted. Overall, in jurisdictions with detoxication centres,(8) approximately one-quarter of the drunkenness arrestees have gained admission to detoxication centres--22% in the first year of operation and 27% in the second (Oki et al., 1976). Furthermore, there is evidence that the proportion of police referrals to detoxication centres compared to other referrals (i.e. hospitals, other agencies, self-referrals) has decreased in four of the nine jurisdictions for which figures are available for two or more years. Overall, the proportion of police referrals was 48% in 1972, 62% in 1973, 49% in 1974, and down to 40% in 1975. However, in Toronto the percentage of police referrals has increased from 41% in 1972 to 46% in 1975.

These findings lead us to the following conclusions:

10. In at least half of communities with detoxication centres, most persons arrested for drunkenness are not taken to the detox but continue to be processed only through the criminal justice system. On average, in the designated areas throughout the province, only 25% of police arrestees for drunkenness are taken to detoxes.

11. In most detoxication centres considerably less than 50% of admissions are referred by police, and in five of nine communities 31% or less were police referrals in 1975. The provincial average presently stands at 40% police referrals. The substantial proportion of self admissions and admission from other social health agencies is not in keeping with the original aims of the system.

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(8) Jurisdictions with detoxication centres now account for over three-quarters of all public drunkenness convictions in Ontario.

IX. *THE PHYSICAL HEALTH OF PUBLIC INEBRIATES*

A major outcome of decreasing incarceration of police arrestees for drunkenness is that such people spend more time at large than they did before 1970. Since the frequent jailing of chronic police arrestees was thought to bring some benefit in terms of their physical health (Giffen et al., 1971), it is reasonable to ask whether one consequence of increased leniency has been a deterioration of the physical health of chronic police arrestees. The available data is suggestive rather than conclusive.

One source of information involves interviews conducted with 80 former or active skid row inebriates (Giesbrecht et al., 1976). The subjects were asked to comment about their own experiences and also about the situations of other skid row individuals. Regardless of age, 54% stated their recent health was worse than it had been a few years ago, and only 11% said it was better. Comments about the perceived changes in the health of *other* inebriates followed a similar pattern: 72% said other "drunks" were in worse health and only 8% said they were in better health. The four most frequently mentioned ailments were: weight loss (15%), arthritis, neuritis, aches and pains (14%), internal disorders (12%), and injuries due to accidents and fights (12%). About 75% of the subjects stated that muggings and beatings of skid row inebriates had increased in recent years. Interview responses by 10 policemen (mainly desk sergeants) of three downtown Toronto divisions and 11 administrators of skid row services (missions, hostels, and drop-in centres) are

generally in agreement with those of the skid row subjects on this topic.(9)

We therefore conclude that:

12. Accounts by skid row inebriates, as well as by policemen and administrators of skid row services, suggest that there has been a deterioration in the physical health of the public inebriate. One possible explanation is that the perceived changes are related to leniency in enforcement and judicial practices together with the limited application of a public health approach. In short, the skid row inebriates have more time at large to drink and fewer interruptions of drinking sprees.

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(9) A comparative study of the physical health of 1961 and 1973 samples of skid row inebriates is in the draft stage.

X. *CHANGES ON SKID ROW*

Skid row inebriates finding themselves in a situation where drinking is not interrupted as often by arrests or jail sentences will have more time at large, and, therefore, more time for drinking and more days when they need to look after sustenance, shelter, and financial resources.

How did members of the skid row population adapt to recent changes in society's response to them? Interviews with 80 active or former male skid row inebriates suggest that the majority have recently had treatment contacts: 77% claim they had been to a detox at least once; 73% said they had been to other treatment institutions; 84% had attended an AA meeting and 50% had been or were a member of an AA group. Most men gave positive assessments of their detoxication experiences; the most prominent answers were: "It's okay, alright"; "A place to rest"; "It helps you get back on your feet." However, the fact that few spontaneously mentioned the referral functions of detoxication units suggests that from their point of view the detox units have become elements in their skid row environment and are not seen by the majority as gateways to rehabilitation.

When the subjects were asked how they and other inebriates were spending the "extra" time outside of jail, "drinking" or "looking for a drink" were the most frequent answers. The men claimed they were drinking outside (parks, alleys, etc.) more often than they were a few years ago, that their consumption of cheap fortified wine had

increased in recent years and that beer consumption had decreased. The men also reported that there had been an increase in pill consumption among skid row inebriates. The interviewed men further claimed that they themselves and other inebriates were eating less often than a few years earlier, and that casual work had declined as a source of income and that welfare, pensions, and begging had become more prominent among members of this population. The authors of the report (Giesbrecht et al., 1976) interpret the retrospective reports of skid row men as indicating an increasing entrenchment into skid row life-styles.

The foregoing leads us to the following conclusion:

13. Attitudes of current skid row alcoholics suggest that detoxication centres are seen primarily as drying-out and care-taking agencies rather than as gateways to rehabilitation. Detoxication centres do not appear to have played a significant role in changing the life-styles of most men on skid row.

CONCLUSIONS

1. The system was planned and built to serve the needs of the chronic drunkenness offender or police arrestee. It was not meant to provide facilities for the detoxication and rehabilitation of all types of alcoholics or intoxicated persons.

2. The key features of the detox-based system have been in operation long enough to establish their contribution to the rehabilitation of the chronic police arrestee.

3. Upward of 50% of detox admissions have not been arrested for drunkenness in the past year, and many admissions have stable accommodation and family ties. (NOTE: Stable accommodation and family ties are typically not found among chronic police arrestees.)

4. There is great variability among detoxication centres in mean length of stay of residents (range 1.8 days to 4.8 days). In some centres, only a small minority of admissions stay less than 24 hours, whereas in other centres, over half of all admissions are discharged within 24 hours.

5. A large proportion of the population periodically establishes contact with other longer-term health facilities. Only about 10% of detox admissions are successfully referred to such facilities on discharge from detox. The referral rate on second and subsequent admissions decreases.

6. Persons admitted to post-detoxication facilities do not have lower rates of detox readmission and drunkenness arrests than those who are not admitted.

7. Premature termination of treatment is the norm for halfway house populations and for detox referrals to both outpatient and residential facilities of all kinds.

8. There is little evidence of positive effects of detox on the clients' post-detox drinking behavior. On the average, arrests after detox admission do not decline. Readmission rates are as high as 70% over two years.

9. Drunkenness arrests showed inconsistent changes after the introduction of the system. Such changes could be as much due to modifications in police and court policies and attitudes as to some specific effect of the detox-halfway house system on the chronic police arrestee.

10. In at least half of communities with detoxication centres, most persons arrested for drunkenness are not taken to the detox but continue to be processed only through the criminal justice system. On average, in the designated areas throughout the province, only 25% of police arrestees for drunkenness are taken to detox.

11. In most detoxication centres considerably less than 50% of admissions are referred by police, and in five of nine communities 31% or less were police referrals in 1975. The provincial average presently stands at 40% police referrals. The substantial proportion of self admissions and admissions from other social health agencies is not in keeping with the original aims of the system.

12. Accounts by skid row inebriates, as well as by policemen and administrators of skid row services, suggest that there has been a deterioration in the physical health of the public inebriate. One possible explanation is that the perceived changes are related to leniency in enforcement and judicial practices together with the limited application of a public health approach. In short, the skid row inebriates have more time at large to drink and fewer interruptions of drinking sprees.

13. Attitudes of current skid row alcoholics suggest that detoxication centres are seen primarily as drying-out and care-taking agencies rather than as gateways to rehabilitation. Detoxication centres do not appear to have played a significant role in changing the lifestyles of most men on skid row.

RECOMMENDATIONS

There are large segments of the population who occasionally drink to the point of intoxication and appear drunk in public. For public monies to be spent on providing detoxication beds for all such cases would not only be prohibitively expensive but would be totally unjustified since many of these individuals have other resources, such as family and friends, that can be drawn upon. This was recognized in the original legislative debates by the then Minister of Health who presented the proposed detoxication program as an alternative to jail for the chronic drunkenness offender, and, at the same time, warned that there were "no hangover havens" in the program budget estimates. It is clear that the intent of the legislators was to provide the detoxication facilities for chronic police arrestees. As long as the police are concerned with public inebriety, arrestees will come to detox centres primarily via police, however if police involvement with this population decreases in the future a larger proportion may be referred by hospitals and social agencies.

Recommendation #1

a. *Whenever possible other resources be drawn upon, and that admission to a detoxication unit be reserved primarily for chronic drunk arrestees who are largely lacking in other support systems.*

b. *Since it is the police who deal primarily with this population, it is recommended that more beds be set aside for police referrals. This may take some time to achieve and it is therefore recommended that within two years at least 75% of beds in each detoxication centre be set aside for police referrals. It is inappropriate to screen*

persons at the door of a detoxication centre to determine whether they are "chronic arrestees." Therefore it is felt that as long as the police are concerned with public inebriety, it is primarily through the police that persons should be admitted to detoxication centres.

c. *All police arrestees should be eligible for voluntary referral to detox units with these exceptions: persons who are wanted on other charges, and/or clearly in need of medical attention--the latter should be referred to hospitals.*

A major intention of the public health approach introduced in the late 1960s was to decriminalize the handling of public inebriates. However, since not all communities have detox centres and those which have such centres do not have a sufficient number of beds to accommodate all drunk police arrestees, a situation of partial decriminalization exists; some arrestees are taken to police cells, charged and perhaps jailed, and others are taken to detox centres where no charges are laid. This situation of partial decriminalization, therefore, involves differential and inequitable methods of dealing with drunk arrestees. In order to establish a fairer system with fuller decriminalization we recommend the following:

Recommendation #2

Police arrestees should be admitted to police cells to detoxify. This should occur when (i) arrestees are picked up by the police for public drunkenness, (ii) they are not wanted on other charges, and (iii) no bed at a detox unit is available for them. It is recognized that implementation of this recommendation may involve a change in legislation. The use of police cells for detoxication without charge should continue until sufficient detox beds are available for chronic police arrestees. (However, we recommend that the current police practice of escorting residentially stable inebriates to their homes--instead of lodging them in police cells or taking them to detox centres--should continue.)

The original detoxication planning figures projected that the majority of drunk arrestees would be detoxified in less than 24 hours (based on time studies of the disappearance of alcohol in the blood of arrestees). The most commonly occurring withdrawal reactions are typically seen within 48 hours of admission (see Appendix G for explanation). Currently in the program, stays of seven or more days have become common with a mean duration of stay of three to four days. It is generally felt that the longer time is frequently required for the resident to gain strength, and make specific rehabilitative plans. Frequently, however, the longer stay does not result in any concrete plans or the acceptance of a referral. At the same time, the number of individuals who can be offered a bed for detoxication is greatly reduced. The original hope that, with repeated longer stay admissions, residents would increasingly become motivated to accept a referral, has largely not been realized. In fact, referral rates are highest on first admission.

It would be desirable (a) to make optimal use of available beds for detoxication purposes, and (b) to improve the assessment and referral process. A two-part program in the detoxication centres, which separated detoxication and referral functions, might prove of value in achieving these objectives.

Recommendation #3

a. *A 12-month pilot study of the following proposal be undertaken at one Toronto detox centre in order to test the workability of this recommendation before considering its application Province-wide.*

b. *Seventy-five percent of the beds in the detoxication centre be allocated to a short-term Detoxication Program, with the remaining 25% allocated to a longer-term Referral Program.*

c. *All admissions be initially assigned to the Detoxication Program. The typical length of time in this program to be 12 to 48 hours.*

d. *Toward the end of the resident's stay in the Detoxication Program, the nature of the Referral Program and the necessity of a signed*

committment would be explained. If after 48 hours the resident chose not to accept admission to the Referral Program he or she would be given information about community services and discharged from the Detoxication Centre.

e. *Admission to the Referral Program would be contingent upon a signed committment by the resident to accept referral to a suitable residential facility and to remain in residence for at least three weeks. The typical length of stay in the Referral Program would be two to six days.*

f. *Residents who broke the signed committment would become ineligible for admission to the Referral Program for a period of 12 months, but would remain eligible for the short-term Detoxication Program.*

The current rate of post-detox referrals is relatively low and rates of premature termination at referral agencies is quite high for members of this population. In order to attempt to improve this situation we recommend greater emphasis be placed both on assessment of persons after their admission to detox centres and on post-detox referral arrangements.

Recommendation #4

a. *Assessments and referrals should be conducted by persons especially trained in assessment techniques and with intimate familiarity with the range of referral options in their local situations. Such referral options would include agencies primarily concerned with rehabilitation and those primarily intended to offer long-term care and support.*

b. *Since assessment for referral has received little systematic investigation particularly with this population, it is recommended that the Addiction Research Foundation undertake studies in this area and that the results of these studies be used in the improvement of assessment and referral procedures, training of detox personnel, and design of resources.*

Following recommendation #2 which recognized that without a considerable expansion of the number of detox beds some drunk arrestees will continue to be taken to police cells, it is recommended as follows:

Recommendation #5

> *That those taken to police cells simply because no detox beds are available be given the opportunity to be referred to a health care facility and especially the opportunity to enter a Referral Program (see recommendation #3) on the same terms as those entering such a program from detox. Therefore, inebriates detoxifying in police cells should be approached and counseled by persons with knowledge of available resources. Details of the implementation of this recommendation will need careful discussion with police departments.*

While we see no justification for a total retreat from the rehabilitative goals of the present detox-halfway house system, it is recognized that some chronic police arrestees have little rehabilitative potential. These include: (a) those who either chronically resist referral to rehabilitation centres or who drop out of such centres before any behavioral change can be induced, and (b) those who typically seek out places where they can stay for long periods without showing any signs of rehabilitation. Any comprehensive system for dealing with chronic drunk arrestees should therefore make some provision for such people.

Recommendation #6

> *That experimental long-term care services be established and carefully evaluated in terms of their ability to attract and retain, at a reasonable cost, chronic arrestees with low rehabilitative potential.*

Since the police play a key role in the handling of chronic public drunks (both in communities with and without detox centres) and since the implementation of the foregoing

recommendations will require increased cooperation between police, justice officials, and health care workers, we recommend as follows:

Recommendation #7

That the present Interministerial Co-ordinating Committee for Detoxication Centres and Halfway Houses be expanded to include one or more senior officers from the Solicitor General's Department, the Attorney General's Department, and the Ontario Police Commission. It is further recommended that every effort be made to facilitate cooperation between police and health care workers throughout the province.

Recommendation #8

That the present Interministerial Co-ordinating Committee for Detoxication Centres and Halfway Houses be asked to give detailed attention to the implementation of the above recommendations.

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APPENDICES

APPENDIX A

The Recommendations Of The Task Force On Detoxication (May, 1969)

(1) The offence of being intoxicated in a public place should be retained in the Liquor Control Act until alternative means of taking care of public inebriates are developed throughout Ontario.

(2) Meanwhile, the police should be specifically empowered by amendment to the Liquor Control Act if necessary, to take public inebriates directly to public detoxication centres or hospitals.

(3) No statutory authority to hold patients will be required by directors of detoxication centres as long as the offence of being intoxicated in a public place remains in force but if it is eliminated directors of detoxication centres should be given authority to retain patients for up to 24 hours.

(4) In the early stages of the proposed new system the persons admitted to detoxication units should be those who would be arrested and charged with public intoxication under the present system, with the exception that inebriates who might be charged with drinking under 21 years of age should be included.

(5) Under the proposed system the police should be vested with responsibility for picking up inebriates from public places and taking them to a detoxication centre or hospital.

(6) In the larger cities specialized detoxication units should be established in conjunction with general hospitals and in smaller centres formal arrangements should be made for detoxication within general hospitals.

(7) Toronto should have one detoxication unit of approximately 125 beds, attached to one of the downtown general hospitals plus arrangements with suburban hospitals to provide beds for inebriates who cannot be brought downtown conveniently.

(8) That a centrally-located "multi-service centre" be established in Toronto to take care of diagnosis and referral for selected multi-problem patients from the detoxication unit.

(9) That new residential treatment facilities should be created specifically for this population with special emphasis on small, inexpensive "self-help" units.

APPENDIX B

Recommendations of the Interdepartmental Committee On Chronic Drunkenness Offenders

(1) The offence of being intoxicated in a public place should be retained in the Liquor Control Act until alternative means of taking care of public inebriates are developed throughout Ontario.

(2) As an interim measure, and as soon as possible, the police should be specifically empowered by amendment to the Liquor Control Act to take public inebriates directly to public detoxication centres or hospitals.

(3) Statutory authority should be provided to enable patients to be detained in a "detoxication centre" for a period not to exceed 24 hours.

(4) In the early stages of the proposed new system, priority should be given to the persons admitted to detoxication units who would be arrested and charged with public intoxication under the present system, with the exception that inebriates who might be charged with drinking under 21 years of age should be included.

(5) (a) Under the proposed system the police should be vested with the responsibility for picking up inebriates from public places and taking them to a detoxication centre or hospital.

(b) Since the detoxication units will be working very closely with the local police forces, emphasis should be given to full involvement of the police in the planning and development of the centres. In addition, emphasis should be placed on educational courses for police designed to ensure that adequate information is made available on a continuing basis.

(6) (a) Metropolitan Toronto should have a total of 125 beds continuously available for recovery from the effects of intoxication and to start the process of rehabilitation.

(b) The maximum number of beds per unit should be 20.

(c) Each of the units should be geographically close to and have a working arrangement with a general hospital to ensure adequate care for those patients who required the intensive treatment available in an emergency department of a hospital. The number requiring "intensive care" will be approximately 5% of the total.

(d) One of the units (approximately 15-20 beds) should be for females.

(7) (a) For those patients who require and can derive benefit from a longer period of care (approximately 30 days) at least six "halfway houses" (10-15 beds each) should be established.

(b) For those patients who need a long period away from an urban environment, facilities such as the "Bon Accord Farm" of the Addiction Research Foundation should be established.

(8) Special facilities for detoxication and rehabilitation of inebriates should be provided in judicial districts where the arrests for public intoxication exceed 1,000 per year. Eleven districts would qualify: York, Middlesex, Wentworth, Thunder Bay, Sudbury, Lincoln, Essex, Kenora & Patricia Carleton, Renfrew, Waterloo.

APPENDIX C:

Location	Name and/or Address	Auspices
Toronto*	Harbord Street	ARF
Toronto*	Seaton House	Social Services, City of Toronto and ARF
Toronto*	Harbour Light	Salvation Army
Toronto*	Street Haven	Street Haven
Toronto**	West Central	Western Gen. Hosp.
Kenora**	Alpha Delta Chi	Lake-of-the-Woods General Hospital
Toronto	410 Dundas	ARF Clinical Inst.
Hamilton	Hamilton	Hamilton Gen. Hosp.
Toronto	St. Michael's	St. Michael's Gen. Hosp.
London	St. Joseph's	St. Joseph's Gen. Hosp.
Sudbury	1237 Kingsway	Laurentian Gen. Hosp.
Ottawa	119 Murray St.	Ottawa Gen. Hosp.
Windsor	363 Mill St.	Windsor Western Hosp. Centre
Thunder Bay	Lewkin	St. Joseph's Gen. Hosp.
Kitchener	466 Park	Kitchener-Waterloo Hosp.
Toronto	109 Knox Ave.	Toronto East General
St. Catharines	10 Adams St.	Hotel Dieu Gen. Hosp.

* Opened and closed before legislation passed.
** Opened before legislation but continuing.

Ontario Detox Centres, 1968 to Present

Beds	Sex	Opening Date	Closing Date
22	M	June 1, 1968	Oct. 31, 1969
12	M	Nov. 11, 1969	Apr. 30, 1970
10	F	Nov. 1, 1969	Apr. 30, 1970
18	M	Sept. 15, 1970	Oct. 10, 1972
14	M	Jan. 1, 1971	Oct. 31, 1972
3	F	July 15, 1971	Aug. 31, 1971
18	M	Nov. 15, 1971	Continuing
20	M	Sept. 1, 1972	Continuing
15	F	Sept. 1, 1972	"
14	M	Nov. 15, 1972	"
6	F	Nov. 15, 1972	"
20	M	Mar. 9, 1973	"
20	M	July 4, 1973	"
20	M	Sept. 9, 1973	"
16	M	Nov. 15, 1973	"
20	M	Jan. 31, 1974	"
20	M	Feb. 4, 1974	"
16	M	Feb. 14, 1974	"
4	F	Feb. 14, 1974	"
18	M	Jan. 6, 1975	"
20	M	May 5, 1975	"
18	M	June 15, 1975	"

APPENDIX D (1)

Characteristics of Detox Clients

Variables	Halfway Houses Males N=747	Detox Units Males N=8112	Detox Units Females N=613
DEMOGRAPHIC:			
Age:			
20 or under	1.0%	2.8%	9.5%
21-35	26.8%	22.6%	35.4%
36-50	52.7%	43.3%	33.4%
51+	20.5%	31.3%	21.7%
(Mean)	(41.9)	(44.1)	(38.5)
(Standard Deviation)	(9.9)	(12.3)	(13.5)
Racial Origin:			
Caucasian	93.1%	87.1%	44.5%
North American Indian	5.4%	6.4%	53.0%
Education:			
Grade 8 or Less	42.2%	41.5%	58.9%
Grade 9-11	39.3%	37.1%	24.5%
Grade 12+	18.5%	21.5%	16.6%
Marital Status:			
Single	31.1%	34.7%	21.2%
Married/ Common-law	10.5%	24.4%	46.2%
Separated/ Divorced/Widowed	58.4%	40.9%	32.6%

(1) Statistics for halfway houses and detoxication centres are based on client-monitoring systems described by Ogborne and Weber (1975) and Annis (1974) respectively.

Appendix D (cont'd.)

Variables	Halfway Houses Males N=747	Detox Units Males N=8112	Detox Units Females N=613
Number of Children:			
None	42.5%	42.5%	26.1%
1 to 2	27.4%	28.6%	32.3%
3+	30.2%	28.9%	41.6%
LIVING ARRANGEMENTS			
Accomodation:			
Apartment/ Housekeeping	28.2%	46.0%	71.9%
Room and Board	10.6%	12.4%	11.7%
Non-Residence/ No Fee/Hotel/Room	61.2%	41.6%	16.3%
EMPLOYMENT:			
Months Employed:			
None	21.8%	31.1%	73.4%
1-6 Months	47.5%	27.3%	13.7%
7+	30.7%	41.6%	12.9%
(Mean)	(4.7)	(5.5)	(1.8)
(Standard Deviation)	(4.1)	(4.8)	(4.2)
TREATMENT (In Past Year)			
Out-Patient Attendance:	14.5%	7.2%	3.9%
(Mean No. of Months) (2)	(2.3)	(3.8)	(2.9)

(2) Mean number of months in treatment for those entering treatment.

Appendix D (cont'd.)

Variables	Halfway Houses Males N=747	Detox Units Males N=8112	Detox Units Females N=613
Residential Treatment:	32.6%	20.3%	10.9%
(Mean No. of Months)(3)	(2.2)	(2.7)	(2.7)
INVOLVEMENT WITH LAW (In Past Year)			
Arrested for Drunkenness:	62.8%	48.1%	50.7%
(Mean No. of Arrests)(4)	(5.4)	(4.7)	(15.2)
Jail Sentence:	41.3%	16.5%	7.0%
(Mean No. of Months)(5)	(1.7)	(3.3)	(3.2)
DRINKING VARIABLES			
Frequency of Drinking: (6)			
Daily	64.3%	66.6%	34.1%
Several Times/ Week	29.1%	16.7%	21.0%
Once a Week or Less	4.5%	16.7%	44.8%

(3) Mean number of months in treatment for those entering treatment.
(4) Mean number of arrests for those arrested.
(5) Mean number of months in jail for those receiving jail sentences.
(6) For the detox units, frequency of drinking statistics are based on only 3,652 males and 504 females.

Appendix D (cont'd.)

NOTE: The inclusion of the Kenora data in the above Table results in a higher proportion of female Indians to male Indians in the detoxication sample. Supplementary analyses comparing female to male admission to the detoxication centres in Toronto and Thunder Bay confirmed the trends shown above; specifically, female admissions were more socially integrated than male admissions (see text).

APPENDIX E(1)

Percentage of Residents with Varying Lengths of Stay in Detoxication Centres Throughout Ontario

Length of Stay	0-5 hrs.	6-23 hrs.	1-2 days	3-4 days	5+ days	(Mean No. Days)
MALES						
Toronto (Dundas)	1.8%	11.4%	9.0%	34.7%	43.1%	(3.9)
Toronto (Adelaide)	7.3%	6.6%	16.3%	26.7%	43.2%	(3.7)
Toronto (Ossington)	15.4%	18.4%	9.0%	15.8%	41.5%	(3.5)
Toronto (East General)	14.1%	12.9%	12.2%	32.6%	28.2%	(2.8)
Hamilton	30.2%	10.5%	9.4%	21.0%	29.0%	(2.7)
London	44.0%	25.6%	7.4%	8.5%	14.6%	(1.8)
Sudbury	20.7%	31.4%	12.9%	18.8%	16.2%	(2.0)
Ottawa	25.3%	23.5%	10.7%	12.5%	28.0%	(2.5)
Thunder Bay	8.5%	26.6%	20.6%	18.6%	25.6%	(2.8)
Windsor	10.5%	13.7%	8.1%	25.8%	41.9%	(4.8)
Kitchener	26.7%	21.3%	9.0%	13.7%	29.3%	(3.1)
St. Catharines	19.6%	18.4%	9.5%	16.3%	36.2%	(4.2)
Kenora	50.6%	45.5%	2.4%	0.9%	0.6%	(0.4)
FEMALES						
Toronto (Dundas)	10.0%	18.6%	18.6%	14.3%	38.6%	(3.3)
Thunder Bay	7.7%	17.9%	17.9%	30.8%	25.6%	(3.4)
Kenora	41.6%	53.9%	2.8%	0.3%	1.4%	(0.5)

(1) Statistics based on client-monitoring system (see Annis, 1974).

APPENDIX F

Total Adult Male Detoxication Admissions for Selected Ontario Jurisdictions 1972-5* Indicating the Proportion of Police and Other Referrals

	1972			1973		
Community	Police	Other	Total	Police	Other	Total
Toronto	41.4 (2,087)	58.6 (2,960)	(5,047)	41.1 (1,810)	58.9 (2,594)	(4,404)
Kenora	92.7 (716)	7.3 (56)	(772)	89.9 (3,716)	10.1 (416)	(4,132)
Hamilton				44.5 (567)	55.5 (707)	(1,274)
London						
Sudbury						
Ottawa						
Windsor						
Thunder Bay						
Kitchener						
TOTALS	48.2 (2,803)	51.8 (3,016)	(5,819)	62.1 (6,093)	37.9 (3,717)	(9,810)
Bed Occupancy (Man Days) Mean Stay	19,004/3.27			31,592/3.22		

* Only includes data for years when detox in operation the full year. Source: Detoxication Coordinating Office, "Detox Statistics" Form, except for Toronto police referral data for 1972-73, which were obtained from the Records Bureau. Metropolitan Toronto Police Department.

1974			1975		
Police	Other	Total	Police	Other	Total
46.1 (2,205)	53.9 (2,575)	(4,780)	45.6 (2,942)	54.4 (3,504)	(6,446)
94.7 (2,148)	5.3 (121)	(2,269)	91.0 (2,271)	9.0 (225)	(2,496)
50.8 (985)	49.2 (954)	(1,939)	24.1 (477)	75.9 (1,504)	(1,981)
55.9 (1,703)	44.1 (1,344)	(3,047)	40.5 (1,771)	59.5 (2,599)	(4,370)
46.1 (649)	53.9 (758)	(1,407)	31.0 (735)	69.0 (1,634)	(2369)
38.1 (889)	61.9 (1,445)	(2,334)	40.3 (1,166)	59.7 (1,724)	(2,890)
11.0 (176)	89.0 (1,423)	(1,599)	9.2 (175)	90.8 (1,720)	(1,895)
24.3 (326)	75.7 (1,014)	(1,340)	21.3 (361)	78.7 (1,333)	(1,694)
			30.7 (607)	69.3 (1,372)	(1,979)
48.5 (9,081)	51.5 (9,634)	(18,715)	40.2 (10,505)	59.8 (15,615)	(26,120)

64,076/3.42 82,140/3.14

APPENDIX G

Delirium Tremens and Seizures

When alcohol ingestion is abruptly decreased or discontinued the alcohol withdrawal syndrome ensues, most typically characterized by the appearance of psychomotor agitation which, if left untreated, may progress to hallucinosis, seizures, and delirium (Johnson, 1961; Sellers and Kalant, 1975). The severity of the signs and symptoms associated with the withdrawal reaction varies with both the intensity and duration of the preceding alcohol exposure (Jellinek, 1959; Johnson, 1961; Sellers and Kalant, 1975). There appears to be little dispute that the onset of the alcohol withdrawal syndrome occurs within 24 hours following the last intake of alcohol (Johnson, 1961; Mendelson and La Dou, 1964), and that the chief symptoms of mild withdrawal have usually subsided after 48 hours (Johnson, 1961; Sellers and Kalant, 1975).

The more severe stages of the alcohol withdrawal syndrome, namely delirium tremens, were found by most observers to occur in only a relatively small percentage of the alcoholic population. Among hospitalized alcoholics, a fairly uniform incidence of approximately 5% who developed delirium tremens has been reported (Victor and Adams, 1953; Kaim et al., 1969; Sellers and Kalant, 1975). As to the onset of delirium tremens in the withdrawal reaction, there appear to be varied reports of the peak period of incidence. Sellers and Kalant (1975) report that delerium tremens, among other states of severe withdrawal reaction, is most evident between 48 and 60 hours following the cessation of drinking, noting that there is considerable variation. Other observers have stated the onset of delirium tremens between 60 and 80 hours (reported in Gross et al., 1973). A more extreme estimate is that of Johnson (1961) who reports that by the end of 72 hours significant improvement has occurred however the total period of withdrawal varies from 7 to 10

days, delirium tremens often not occurring until three to four days after the last alcohol intake (Victor and Adams, 1953).

Seizures occurring during the alcohol withdrawal syndrome are typically grand mal in nature, non-focal, and one or two in number (Sellers and Kalant, 1975). As in the case of delirium tremens, observers differ as to the peak incidence of seizures. Victor and Brausch (1967) report that 90% of cases of seizures occurred between 7 and 48 hours; two-thirds of the cases of seizures occurred within 24 hours after cessation of alcohol intake and almost all (94%) had occurred by 48 hours. The peak incidence was between 13 and 24 hours. Sellers and Kalant (1975), on the other hand, report that seizures are most likely to occur between 31 and 48 hours. Despite the conflict among observers as to the period of peak occurrences, there appears to be a general view that most seizures will occur within 48 hours following last alcohol intake (Victor and Adams, 1953; Victor and Brausch, 1972; Sellers and Kalant, 1975).

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APPENDIX H

Summaries of Referenced Reports on the Ontario Detoxication and Halfway House System

Annis, H.M. An Evaluation System for Ontario Detoxication Centres. ARF Substudy No. 583, 1974.

This report presents the patient monitoring system being implemented within provincially-financed detoxication centres coming under the Personal Care Division of the Ministry of Health. The funding, staffing, and objectives of the detoxication program are described and major questions being addressed by the research monitoring system are outlined. The system is designed to permit comparison of the demographic, accommodation, employment, drinking, treatment, and arrest histories of male and female populations being served by the detoxication centres in the various regions across the province. The system will also permit assessment of the extent to which the centres are serving chronic inebriates, whether or not the centres are creating a faster revolving door for the public inebriate, and the role being played by the detoxication centres in integrating the chronic inebriate into existing health and social services in the community. Some descriptive statistics of male and female detoxication populations are presented based on a three-month pilot study of the monitoring system in one of the detoxication centres.

Annis, H.M. Self-Report Reliability of Skid Row Alcoholics. ARF Substudy No. 729, 1975.

The question of reliability of response is a critical methodological issue that has been largely neglected in the evaluation of alcoholism treatment programs. This report explores the stability of self-report of 72 skid-row alcoholics over a

one to six month interval. High response agreement on reinterview was found for demographic items including age, marital status, number of children, and education. This finding parallels similar low discrepancy rates for "life-time identity" items reported in previously published studies of skid-row men. However, less reliability was observed on items assessing recent employment history, other treatment contacts, recent arrests and incarcerations, and current drinking patterns. It is precisely in these areas of social functioning and drinking patterns that the reliability of self-reports is of critical importance when follow-up interviews are to evaluate treatment programs. Implications of the measurement error introduced by the unreliability of self-reports in this area is discussed. It is suggested that a statistical estimate of the magnitude of such error for each outcome criterion be incorporated in the design of large sample studies evaluating alcoholism treatment programs. However, in the typical small sample follow-up study, use of alternative evaluative procedures or collaborative sources of information is recommended.

Annis, H.M. and Liban, P. Drunkenness Arrests and Detoxication in the Hamilton Area. ARF Substudy No. 717, 1975.

An interim examination is presented of changes in the handling of public drunkenness offenders in Hamilton after two years of operation of the detoxication centre. Three lines of evidence are discussed:

(1) reported drunkenness offences prior to and subsequent to the opening of the detoxication centre;

(2) police-escorted admissions to the centre in relation to total arrest rates;

(3) the arrest and treatment histories of a sample of men before and after the opening of the centre.

Paralleling the findings of the Toronto study (Annis and Smart, 1974), it was concluded that the detoxication system in Hamilton falls far short of providing a viable alternative to incarceration for the majority of drunkenness offenders.

Only 15% of eligible arrestees are admitted to the detoxication centre. To date, the centre has had no demonstrable impact on the rate of drunkenness occurrences in Hamilton. Admission to the detoxication centre has had no effect on men's subsequent rate of re-arrest for drunkenness. However, there is evidence of an increase in integration of detox clientele into some parts of the health care system. Documentation is presented on the acute nature of the retention problem with this population in the various facilities of the health care network.

Annis, H.M. and Liban, P. A Follow-Up Study of Halfway House Residents and Matched Non-Resident Controls. ARF Substudy No. 761, 1976.

From a large population of men who had undergone detoxication in a number of provincially-financed facilities, a sample was drawn of 35 men who had entered five halfway houses following discharge, and a matched control sample of 35 men who had not entered a halfway house. Paired matching of men in the experimental and control samples was achieved simultaneously on seven behavioral variables involving their employment, arrest, and treatment contacts in the preceding year; additionally, group matching was achieved on four demographic variables (mean age, race, marital status, and mean years of education). "This procedure resulted in the equating of halfway house and control samples on characteristics that have been found to relate significantly to treatment outcomes." Detox readmissions and arrests for public intoxication were documented for each of the 70 men in the study over a three month follow-up period. It was found that almost half (49%) of the halfway house sample were readmitted to a detox unit within three months of their discharge from a halfway house and 6% were arrested during this period on a drunkenness charge. Men in the halfway house sample had more detox readmissions but fewer drunkenness arrests in the follow-up period than their matched controls. Further explanatory analyses are presented and implications of the findings for the rehabilitation of the chronic drunkenness offender are discussed.

Annis, H.M. and Liban, P. Re-admission to an Alcoholic Detoxication Centre: Demographic, Behavioural and Detox-Related Predictors. ARF Substudy No. 760, 1976.

The readmissions of 522 men drawn from three detoxication centres located within metropolitan areas of Ontario were traced over a two-year period. Multiple Classification Analysis was employed in the prediction of detox re-admissions of the men. A three stage path model was developed involving sets of logically prior variables: I *demographic variables* (age, marital status, education, employment type), II *behavioral variables* (a) drinking (alcoholic beverage type, frequency, consumption level) and (b) non-drinking (months in jail, residential treatment, outpatient treatment, arrests, accommodation, months employed, employment status at time of detox admission), and III *detox-related variables* (source of referral to detox, hours in detox, post-detox referral). This model was found capable of explaining 18% of the variance in detox readmissions. Variables at the behavioral level were most powerful, but both demographic and detox-related variables were shown to contribute unique predictive power.

Annis, H.M. and Smart, R.G. A Follow-up of Men Admitted to Detoxication Facilities: Arrests, Re-admissions and Treatment Involvement. ARF Substudy No. 762, 1976.

A follow-up was conducted of 522 male first admissions to three Ontario detoxication centres. A comprehensive search was made of all record files on the men held by police, detoxication centres, and residential and outpatient treatment facilities. Over a six month post-detox follow-up period: 1) slightly less than half of the men were arrested, with one-quarter having three or more arrests; 2) over half of the men were readmitted to detoxication centres, with one-fifth having at least three detox readmissions; 3) over one-third of the men entered residential treatment and one-quarter were admitted to outpatient programs; 4) the predominant pattern among the men was one of multiple involvement with police, detox, residential, and outpatient facilities. About half of those admitted to rehabilitation

programs were also arrested by the police during the follow-up period. The profile that emerged was one of a very quickly revolving door within both the law enforcement and health care sectors.

Annis, H.M. and Smart, R.G. The Ontario Detoxication System: Influence on Drunkenness Arrests in Toronto. Ontario Psychologist, 7(4), 19-24, 1975.

An interim assessment is presented of the effect that the detoxication centres have had on the handling of public inebriates in Toronto. The original planning guidelines for the Ontario system assumed that, in the early years of operation, all beds would be allocated to police referrals and that the majority of persons would be detoxified in less than 24 hours. In practice, however, it was found that in Toronto only one-third of the beds are reserved for police use, and that the average duration of stay is 3.9 days. Evidence was presented that the number of drunkenness arrests has not decreased in the years following the opening of the Toronto detoxication centres, and that only a small percentage (11%) of eligible drunkenness offenders have gained access to the centres while the majority of arrestees continue to be placed in the police lock-up and processed through the courts. It was concluded that either a 10-fold expansion of facilities or major readjustments in admission and retention policy would be needed before the detoxication system could provide a real alternative to the criminal process for most public inebriates in Toronto.

Giesbrecht, N., Giffen, P.J., Lambert, S. and Oki, G. Changes in the Social Control of Skid-Row Inebriates: The Views of Policemen, Administrators of Services and 'Skid-Row' Inebriates. ARF Substudy No. 763, 1976.

This study involved interviews with 10 policemen (mainly desk sergeants in three downtown divisions, 11 administrators of 'skid row' services (1972) and 80 'skid row' inebriates (1973). The policemen and administrators of services, as

well as the 'skid row' subjects, were generally in favor of the new emphasis on public health approaches to the problem. However, the police stated that there had not been a substantial reduction in their workload, and claimed that the inebriates were not being taken out of circulation long enough. Both the policemen and the administrators claimed that with the new arrangements public drunkenness was becoming more visible, the drinking was more likely to be prolonged and there was likely to be deterioration in the public inebriates' health and possibly a higher death rate in this population.

About a third of the 80 skid row subjects claimed that they had increased their drinking in recent years, and a number said that they were spending their 'extra' time--because of fewer jail sentences, etc.--drinking, or looking for a drink. The majority of the subjects said they were drinking more wine than they had been a few years ago and that they were doing more of their drinking outside. Over half of them (54%) claimed their health had deteriorated, and 49% claimed that they were eating less often than they had a few years ago. About 75% had been to a detoxication centre and most of the assessments were positive, with the comments emphasizing caretaker benefits of the centres. However, none of the subjects commented on detoxication units as a referral resource.

The results suggest that the skid row inebriates have generally responded to the changes in social control by becoming more entrenched in skid row lifestyles.

Ogborne, A., Ittig, V. and Weber, S. Characteristics and Progress of Male Alcoholics Admitted to Halfway Houses in Ontario: A Preliminary Report. ARF Substudy No. 752, 1976.

This report summarizes data abstracted from the intake forms of 747 consecutive male admissions to 17 Ontario halfway houses. Length of stay and discharge information is also presented for 628 (84%) of the intake sample; the remainder had not discharged at the time of the report.

Intake data indicated that the houses were admitting men with a wide range of characteristics, although the high

incidence of certain characteristics suggested that the 'model' halfway house resident had a severe alcohol problem, was socially isolated, frequently unemployed, and with a history of arrest, incarceration, and familiarity with institutional living.

Seventy percent of the sample had been in a detox. When compared with a sample of males drawn from detox, the halfway house sample showed as less heterogeneous and as generally less socially integrated than the detox sample.

The median stay of those discharged at the time of the report was 5.8 weeks. Twenty-six percent stayed for three months or longer--three months being the time usually considered minimal for residency in a halfway house. Only 18% of all discharges were staff approved and over 70% of men were discharged to an unknown or to an address which would not indicate successful rehabilitation, e.g. to hospital, halfway house, detox, skid row accommodation.

Ogborne, A. and Smart, R.G. Halfway Houses for Skid Row Alcoholics: A Search for Empirical Evaluation. ARF Substudy No. 632, 1974.

This paper critically reviews twelve reports which include data relevant to the evaluation of halfway houses for skid row men. In general, the quality of the reports was poor and they did not give convincing accounts of the value of particular halfway house programs. In so far as generalizations were possible the accumulated evidence did not convince the authors that halfway houses played a significant role in the rehabilitation of skid row men. Rather the houses on which these reports were based tended to attract and to be of greatest benefit to those who had some social and educational advantages over those traditionally trapped in skid row and the revolving door of the drunk tank.

Ogborne, A. and Weber, S. A Data Collection System for Halfway Houses. ARF Substudy No. 662, 1975.

This paper reports the development and implementation of a system for monitoring intake, discharge, and follow-up for halfway houses in Ontario. A copy of the intake form is included in the report as is a manual explaining how this form should be completed. No data was available at the time of preparing this report.

Oki, G., Giesbrecht, N., Giffen, P.J. and Lambert, S. Decriminalization of Public Drunkenness: A Statistical Profile of Patterns and Trends. ARF Substudy No. 740, 1976.

Police, court, and detoxication admission data were examined in order to draw conclusions about decriminalization in Ontario between 1961 and 1975. The results were examined in terms of leniency and selectivity by the police and courts and diversion to detoxication centres.

There has been a decrease in drunkenness convictions in four of nine jurisdictions examined and increase in only one between 1961-1974. In Toronto the rate of drunkenness charges went from 21 per 1,000 adults in 1961 to 10.5 in 1974. In Ontario suspended sentences have been on the increase—8% in 1961 and 35% in 1971--whereas fines have declined—89% to 53% over the same ten years. In Toronto, jail sentences were found to be shorter and fines smaller and the estimated man-days in jail decreased from 121,095 to 13,380 from 1961 to 1971.

In most jurisdictions with detoxication centres, the majority of persons arrested are not diverted to these centres. Overall about 25% of those arrested for drunkenness are referred to detoxication centres. In Toronto the proportion of arrestees referred to a detoxication centre went from 11% to 13% between 1972-1975. The proportion of police referrals compared to all detox admissions has usually been less than 50% for the province, although it was 62% in 1973 and then dropped to 40% by 1975. In Toronto the proportion of police referrals increased from 41% to 46% in 1975. Overall, in 1975 in five of the nine communities with detox, 30% or less of the referrals were by the police. The authors conclude that while there is clear

evidence of increased leniency and selectivity the diversion to detox has not been consistent from one community to the next and overall only accounts for one-quarter of police arrestees.

Smart, R.G., Finley, J. and Funston, R. The Effectiveness of Post-Detoxication Referrals: Effects on Later Detox Admissions, Drunkenness and Criminality. ARF Substudy No. 668, 1975.

This study concerned the relative effectiveness of post-detox referrals to a variety of treatment facilities. The purpose was to discover (i) the proportion of men accepting referrals who actually arrived, (ii) the differences in outcome for patients attending an outpatient clinic, a halfway house, and a long stay form, (iii) the differences in outcome for patients treated in one of the above facilities compared to similar patients not receiving treatment.

In all, 114 male detox admissions were included. However, only 60% arrived even when firm referrals were made. Those arriving and not arriving did not differ in social or demographic characteristics, nor did those who were referred to the various treatment facilities. However, the referral group had more detox admissions in the post detox period. There were no post-treatment overall differences between all treated and untreated patients in detox admissions, arrests for drunkenness, or criminal convictions. Refusals were more often successes than the treated or untreated groups but this is due to their better prognosis at intake. In general, the data provide little cause for optimism about the value of post-detox referrals.

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